Clinical Practice Guideline

Smoking Cessation

Quick Reference Guide for Smoking Cessation Specialists

Number 18

Smoking Cessation: Information for Specialists

U.S. Department of Health and Human Services
Public Health Service
Agency for Health Care Policy and Research
Centers for Disease Control and Prevention

Attention Smoking Cessation Specialists:

The *Clinical Practice Guideline* on which this *Quick Reference Guide for Smoking Cessation Specialists* is based was developed by an interdisciplinary, private-sector panel comprising health care professionals and consumer representatives sponsored by the Agency for Health Care Policy and Research (AHCPR) and the Centers for Disease Control and Prevention (CDC). Panel members were:

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Special consultants to the panel were Timothy Baker, PhD; Victor Hasselblad, PhD; and David Schriger, MD, MPH.

The panel employed an explicit, science-based methodology along with expert clinical judgment to develop specific statements on smoking cessation interventions. Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Once the guideline was written, the panel conducted a peer review to evaluate the validity, reliability, and utility of the guideline in clinical practice.

This *Quick Reference Guide for Smoking Cessation Specialists* presents a clinical strategy for applying the statements and recommendations from the *Clinical Practice Guideline.* The latter provides a description of the guideline development process, thorough analysis and discussion of the available research, critical evaluation of the assumptions and knowledge of the field, more complete information for health care decisionmaking, and references. Decisions to adopt particular recommendations from either publication must be made by practitioners in light of available resources and circumstances presented by the individual patient.

AHCPR invites comments and suggestions from users for consideration in developing and updating future guidelines. Please send written comments to:

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Abstract

This *Quick Reference Guide for Smoking Cessation Specialists* contains strategies and recommendations from *Smoking Cessation Clinical Practice Guideline No. 18,* designed to assist clinicians, smoking cessation specialists, and health care administrators/insurers/purchasers in identifying tobacco users and supporting and delivering effective smoking cessation interventions. These recommendations were made as a result of an exhaustive and systematic review and analysis of the scientific literature. The primary analytic technique used was meta-analysis.

This *Quick Reference Guide for Smoking Cessation Specialists* highlights the recommendations for successful smoking cessation treatment:

- Every person who smokes should be offered smoking cessation treatment at every office visit.
- Clinicians should ask and record the tobacco-use status of every patient.
- Cessation treatments even as brief as 3 minutes a visit are effective.
- More intense treatment is more effective in producing long-term abstinence from tobacco.
- Nicotine replacement therapy (nicotine patches or gum), clinician-delivered social support, and skills training are the three most effective components of smoking cessation treatment.[a]
- Health care systems should make institutional changes that result in the systematic identification of, and intervention with, all tobacco users at every visit.

Recommendations for smoking cessation specialists are:

- Assess the smoker who has entered an intervention program.
- Use a variety of clinical specialists.
- Ensure that the program is sufficiently intensive.
- Use a variety of program formats.
- Include effective counseling techniques.
- Target the smoker's motivation to quit.
- Provide relapse prevention intervention.
- Offer nicotine replacement therapy.
- Arrange followup contact.

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[a] As this guideline went to press, nicotine nasal spray was approved for use in the United States by the Food and Drug Administration, joining the nicotine patch and gum as effective available interventions.

Suggested Citation

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Smoking Cessation: Information for Specialists

Purpose and Scope

Tobacco use has been cited as the chief avoidable cause of illness and death in our society. It is responsible for more than 400,000 deaths in the United States each year. Smoking is a known cause of cancer, heart disease, stroke, and chronic obstructive pulmonary disease.

The use of tobacco is surprisingly prevalent, given the health dangers it presents and the public's awareness of those dangers. Recent estimates are that 25 percent of Americans smoke. Moreover, smoking prevalence among adolescents appears to be rising, with more than 3,000 children and adolescents becoming addicted to tobacco each day.

Tobacco use is not only dangerous to individuals but yields staggering societal costs as well. The estimated 1993 cost for smoking-related medical care was $50 billion, and the cost of lost productivity and forfeited earnings due to smoking-related disability has been estimated at $47 billion per year. This *Quick Reference Guide for Smoking Cessation Specialists* presents highlights from the *Clinical Practice Guideline*'s recommendations for smoking cessation specialists.

The *Clinical Practice Guideline on Smoking Cessation* contains six major recommendations:

1. Every person who smokes should be offered smoking cessation treatment at every office visit.
2. Clinicians should ask and record the tobacco-use status of every patient.
3. Cessation treatment even as brief as 3 minutes is effective.
4. The more intense the treatment, the more effective it is in producing long-term abstinence from tobacco.
5. Nicotine replacement therapy (nicotine patches or gum), clinician-delivered social support, and skills training are effective components of smoking cessation treatment.
6. Health care systems should be modified to routinely identify and intervene with all tobacco users at every visit.

Role of the Smoking Cessation Specialist

Specialists are a vital resource in smoking cessation efforts, not only through their important contributions to cessation research but also through their critical role in service delivery — especially in intensive cessation interventions. Specialists contribute to smoking cessation efforts in additional ways as well. These include:

- Training nonspecialists in counseling strategies, providing consultation on difficult cases, and providing specialized assessment services.
- Developing and evaluating changes in office/clinic procedures that increase the rates at which smokers are identified and treated.
- Conducting evaluation research to determine the effectiveness of ongoing smoking cessation activities in relevant institutional settings.
- Developing and evaluating innovative treatment strategies that increase the cost-effective delivery of smoking cessation services.

Recommendations

Assess the Smoker who Has Entered a Program

Assess whether participants in smoking cessation programs are motivated to quit. Specialists may also conduct other assessments that can provide information useful in counseling. For example, such assessments may reveal the presence of high stress levels caused by other issues in a smoker's life or may reveal the presence of other pschological or medical conditions that will affect success in quitting.

Use a Variety of Clinical Specialists

Multiple types of clinicians should be used in intensive smoking cessation programs. One strategy would be to have a medical/health care clinician deliver messages about health risks and benefits, and nonmedical clinicians deliver psychosocial or behavioral interventions.

Ensure that the Program is Intensive Enough

Because of evidence of a strong dose-response relation, the program should include the following elements:

- Session length—at least 20–30 minutes in length.
- Number of sessions—at least 4–7 sessions.
- Length in weeks—at least 2 weeks.

Use a Variety of Program Formats

Either individual or group counseling may be used. Specialists may also use supplementary self-help materials.

Strategy 1. Findings relevant to the specialist's implementation of intensive cessation programs

- There is a strong dose–response relation between counseling intensity and cessation success. In general, the more intense the cessation intervention, the greater the rate of smoking cessation. Treatments may be made more intense by increasing (a) the length of individual treatment sessions and (b) the number of treatment sessions and number of weeks over which treatment is delivered.
- Valid predictors of outcome are available. For instance, high levels of dependence, psychiatric comorbidity, and low levels of motivation to quit all predict greater likelihood of relapse. These measures might be used to adjust treatment intensity, to match patients with particular types of treatment, or for research purposes.
- Many different types of cessation providers (physicians, nurses, dentists, psychologists, pharmacists, etc.) are effective in increasing rates of smoking cessation, and involving multiple types of providers appears to enhance cessation rates.
- Both individual and group counseling are effective smoking cessation formats.
- Particular counseling contents are especially effective. Problem-solving/general skills-training approaches and the provision of intratreatment support are associated with significant increases in cessation rates, as are aversive smoking techniques (e.g., rapid smoking).
- Pharmacotherapy in the form of nicotine patch or nicotine gum therapy consistently increases smoking cessation rates regardless of the level of adjuvant behavioral or psychosocial interventions. Therefore, its use should be encouraged.
- Smoking cessation interventions are effective across diverse populations: across gender, racial, and ethnic groups; across age groups; in pregnant women; etc.

Include Effective Counseling Techniques

Interventions should include problem solving/skill training content as well as clinician-delivered social support for quitting. Strategy 2 illustrates common elements of problem solving/skill training content. Strategy 3 illustrates social support components.

Target the Smoker's Motivation To Quit

Even though a smoker is enrolled in an intervention, he or she may still be uninformed, concerned about the effects of quitting, or demoralized because previous attempts to quit have been unsuccessful. This individual may respond to a motivational intervention. Such an intervention should follow the "4 Rs":

Relevance. Make the motivation relevant to the person's disease status, family or social situation, health concerns, age, gender, and other characteristics, such as prior quitting.

Risks. Review with the individual the potential risks associated with smoking. Have him or her identify the risks, and highlight the ones that

Strategy 2. Common elements of problem-solving/ skills-training smoking cessation treatments

Problem-solving treatment component	Examples
Recognition of danger situations—Identification of events, internal states, or activities that are thought to increase the risk of smoking or relapse.	■ Being around other smokers ■ Being under time pressure ■ Getting into an argument ■ Experiencing urges or negative moods ■ Drinking alcohol
Coping skills—Identification and practice of coping or problem-solving skills. Typically, these skills are intended to cope with danger situations.	■ Learning to anticipate and avoid danger situations ■ Learning cognitive strategies that will reduce negative moods ■ Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure ■ Learning cognitive and behavioral activities that distract attention from smoking urges
Basic information—Provision of basic information about smoking and successful quitting.	■ The nature/timecourse of withdrawal ■ The addictive nature of smoking ■ The fact that any smoking (even a single puff) increases the likelihood of full relapse

are most personally relevant. Emphasize that smoking low-tar/nicotine cigarettes or using other forms of tobacco (e.g., smokeless tobacco, pipes, cigars) will not eliminate the risks. Examples of risks include:

- Acute Risks—Shortness of breath; Worsening of asthma; Impotence; Infertility; Increased serum carbon monoxide.
- Long-Term Risks—Heart attacks and strokes; cancer (lung, larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix, leukemia); chronic obstructive pulmonary diseases (chronic bronchitis, emphysema).
- Environmental risks—Increased risk of lung cancer in spouse and children; higher rates of smoking by children of smokers; increased risk for SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards. Ask the patient to identify the potential benefits of quitting, and highlight those that seem most relevant. Examples include:

- Improved health.
- Food will taste better.
- Improved sense of smell.
- Save money.
- Feel better about yourself.

Strategy 3. Common elements of supportive smoking cessation treatments

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	■ Note that effective cessation treatments are now available. ■ Note that half of all people who have ever smoked, have now quit. ■ Communicate belief in patient's ability to quit.
Communicate caring and concern.	■ Ask about how patient feels about quitting. ■ Directly express concern and willingness to help. ■ Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	**Ask about:** ■ Reasons the patient wants to quit ■ Difficulties encountered while quitting ■ Success the patient has achieved ■ Concerns or worries about quitting
Provide basic information about smoking and successful quitting.	■ The nature/timecourse of withdrawal ■ The addictive nature of smoking ■ The fact that any smoking (even a single puff) increases the likelihood of full relapse

- Home, car, breath will smell better.
- Can stop worrying about quitting.
- Set a good example for the children.
- Have healthy babies and children.
- No worries about exposing others to smoke.
- Feel better physically.
- Freedom from addiction.
- Perform better in sports.

Repetition. Repeat the motivational intervention as needed.

Provide Relapse Prevention Intervention

Most relapses occur soon after a person quits smoking, although some people relapse months or years after the quit date. Therefore, specialists should work to prevent long-term risks of relapse. These interventions can occur during treatment sessions or during followup contacts.

- Congratulate the person and encourage him or her to remain abstinent.
- Encourage active discussion of the benefits the person has derived from quitting, his/her success in quitting, problems encountered, and anticipated potential problems.

Several specific problems are frequently reported. These are listed below along with possible responses:

Weight gain. Make dietary, exercise, or lifestyle recommendations, or include the person in a program that focuses on this issue. Reassure him or her that some weight gain after quitting is common and that significant dietary restrictions soon after quitting may be counterproductive. Consider nicotine gum as a strategy to delay weight gain.

Negative mood or depression. Discuss with the person's primary care physician the possibility of prescribing appropriate medication or referral to a specialist.

Prolonged withdrawal symptoms. If the person reports prolonged craving or other withdrawal symptoms, discuss with his or her primary care physician the possibility of extending nicotine replacement therapy.

Lack of support for cessation. Schedule followup calls with the person, help him or her identify sources of support within his/her environment, or intensify social support counseling.

Include Nicotine Replacement Therapy

Except in special circumstances, every smoker should be offered nicotine replacement therapy. The nicotine patch and nicotine gum are particularly useful in helping smokers quit. As this guideline went to press, nicotine nasal spray was approved for use in the United States by the FDA. Strategy 4 provides general guidelines on the use of nicotine replacement products; Strategies 5 and 6 provide specific instructions and precautions for the nicotine patch and nicotine gum.

Strategy 4. Clinical guidelines for prescribing nicotine replacement products

Who should receive nicotine replacement?	Available research shows that nicotine replacement generally increases rates of smoking cessation. *Therefore, except in the presence of serious medical precautions, the clinician should encourage the use of nicotine replacement with patients who smoke.* Little research is available on the use of nicotine replacement with light smokers (e.g., those smoking 10–15 cigarettes/day or less). If nicotine replacement is to be used with light smokers, a lower starting dose of the nicotine patch or nicotine gum should be considered.
Should nicotine replacement therapy be tailored to the individual smoker?	Research does not support the tailoring of nicotine patch therapy (except with light smokers as noted above). Patients should be prescribed the patch dosages outlined in Strategy 5. Research supports tailoring nicotine gum treatment. Specifically, 4-mg gum, as opposed to 2-mg gum, can be used with patients who are highly dependent on nicotine (e.g., those smoking more than 20 cigarettes/day, those who smoke immediately upon awakening, and those who report histories of severe nicotine withdrawal symptoms). Clinicians may also recommend the higher gum dosage if patients request it or have failed to quit using the 2-mg gum.
Should patients be encouraged to use the nicotine patch or nicotine gum?	Although both pharmacotherapies are efficacious, nicotine patch therapy is preferable for routine clinical use. This preference is based on the following comparisons with nicotine gum therapy: ■ Nicotine patch therapy is associated with fewer compliance problems that interfere with effective use. ■ Nicotine patch therapy requires less clinician time and effort to train patients in its effective use. The following factors support the use of nicotine gum: ■ Patient preference. ■ Previous failure with the nicotine patch. ■ Contraindications specific to nicotine patch use (e.g., severe skin reactions).

Strategy 5. Suggestions on the clinical use of the nicotine patch

Patient selection	Appropriate as a primary pharmacotherapy for smoking cessation. For suggestions regarding use in special populations, see Strategy 4.
Precautions	*Pregnancy*— Pregnant smokers should first be encouraged to attempt cessation without pharmacologic treatment. The nicotine patch should be used during pregnancy only if the increased likelihood of smoking cessation, with its potential benefits, outweighs the risk of nicotine replacement and potential concomitant smoking. Similar factors should be considered in lactating women. *Cardiovascular diseases*— Although not an independent risk factor for acute myocardial events, the nicotine patch should be used only after consideration of risks and benefits among particular cardiovascular patient groups: those in the immediate (within 4 weeks) post-myocardial infarction period, those with serious arrhythmias, and those with severe or worsening angina pectoris. *Skin reactions*— Up to 50% of patients using the nicotine patch will have a local skin reaction. Skin reactions are usually mild and self-limiting, but may worsen over the course of therapy. Local treatment with hydrocortisone cream (5%) or triamcinolone cream (.5%) and rotating patch sites may ameliorate such local reactions. In less than 5% of patients do such reactions require the discontinuation of nicotine patch treatment.
Dosage	Treatment of 8 weeks or less has been shown to be as efficacious as longer treatment periods. Based on this finding, the following treatment schedules are suggested as reasonable for most smokers. Clinicians should consult the package insert for other treatment suggestions. Finally, clinicians should consider individualizing treatment based on specific patient characteristics, such as previous experience with the patch, amount smoked, degree of addictiveness, etc.[a] **Brand** — **Duration** — **Dosage** Nicoderm and Habitrol — 4 weeks — 21 mg/24 hours then 2 weeks — 14 mg/24 hours then 2 weeks — 7 mg/24 hours Prostep — 4 weeks — 22 mg/24 hours then 4 weeks — 11 mg/24 hours Nicotrol — 4 weeks — 15 mg/16 hours then 2 weeks — 10 mg/16 hours then 2 weeks — 5 mg/16 hours
Prescribing instructions	*No smoking* while using the patch. *Location*— At the start of each day, the patient should place a new patch on a relatively hairless location between the neck and waist. *Activities*— No restrictions while using the patch. *Time*— Patches should be applied as soon as patients waken on their quit day.

[a] These dosage recommendations are based on a review of the published research literature and do not necessarily conform to packet insert information.

Strategy 6. Suggestions for the clinical use of nicotine gum

Patient selection	Appropriate as a primary pharmacotherapy for smoking cessation. For suggestions regarding use in special populations, see Strategy 4.
Precautions	*Pregnancy*—Pregnant smokers should first be encouraged to attempt cessation without pharmacologic treatment. Nicotine gum should be used during pregnancy only if the increased likelihood of smoking cessation, with its potential benefits, outweighs the risk of nicotine replacement and potential concomitant smoking. *Cardiovascular diseases*—Although not an independent risk factor for acute myocardial events, nicotine gum should be used only after consideration of risks and benefits among particular cardiovascular patient groups: those in the immediate (within 4 weeks) postmyocardial infarction period, those with serious arrhythmias, and those with severe or worsening angina pectoris. *Side effects*—Common side effects of nicotine chewing gum include mouth soreness, hiccups, dyspepsia, and jaw ache. These effects are generally mild and transient, and can often be alleviated by correcting the patient's chewing technique (see *Prescribing instructions* below).
Dosage	Nicotine gum is available in 2-mg and 4-mg (per piece) doses. Patients should be prescribed the 2-mg gum except in special circumstances outlined in Strategy 4. The gum is most commonly prescribed for the first few months of a quit attempt. Clinicians should tailor the duration of therapy to fit the needs of each patient. Patients using the 2-mg strength should use not more than 30 pieces/day, whereas those using the 4-mg strength should not exceed 20 pieces/day. (Information on tailoring the dose of nicotine gum is presented in Strategy 4.)
Prescribing instructions	*No smoking* while using the gum. *Chewing technique*—Gum should be chewed slowly until a "peppery" taste emerges, then "parked" between cheek and gum to facilitate nicotine absorption through the oral mucosa. Gum should be slowly and intermittently "chewed and parked" for about 30 minutes. *Absorption*—Acidic beverages (e.g., coffee, juices, soft drinks) interfere with the buccal absorption of nicotine, so eating and drinking anything except water should be avoided for 15 minutes before and during chewing. *Scheduling of dose*—Patients often do not use enough gum to get the maximum benefit: they chew too few pieces per day and they do not use the gum for a sufficient number of weeks. Instructions to chew the gum on a fixed schedule (at least one piece every 1–2 hours) for at least 1–3 months may be more beneficial than ad lib use.

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Notes

Notes

Availability of Guidelines

For each clinical practice guideline developed under the sponsorship of the Agency for Health Care Policy and Research (AHCPR), several versions are produced to meet different needs.

The *Clinical Practice Guideline* presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references.

The Quick Reference Guide for Smoking Cessation Specialists is a distilled version of the *Clinical Practice Guideline*, with summary points for ready reference on a day-to-day basis. The *Quick Reference Guide for Primary Care Clinicians* contains information from the *Clinical Practice Guideline* presented in an even more condensed version as a pocket guide for the busy clinician.

The *Consumer Version*, available in English and Spanish, is an information booklet for the general public to increase consumer knowledge and involvement in health care decisionmaking.

To order single copies of guideline products and the meta-analysis reference list or to obtain further information on their availability, call the AHCPR Publications Clearinghouse toll-free at 800-358-9295 or write to: AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907.

Single copies of the *Clinical Practice Guideline* are available for sale from the Government Printing Office, Superintendent of Documents, Washington, DC 20402, with a 25-percent discount given for bulk orders of 100 copies or more. The quick reference guides and the *Consumer Version* in English and Spanish are also available for sale in bulk quantities only. Call (202) 512-1800 for price and ordering information.

The *Guideline Technical Report* contains complete supporting materials for the *Clinical Practice Guideline*, including background information, methodology, literature review, scientific evidence tables, recommendations for research, and a comprehensive bibliography. It is available from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. Call (703) 487-4650 for price and ordering information.

The full text of guideline documents and the meta-analysis references for online retrieval are available on Internet through the AHCPR Web site. Access the guideline products by using a Web browser, specifying URL http://www.ahcpr.gov/guide/ and clicking on "Clinical Practice Guidelines Online."

A fact sheet describing Online Access for Clinical Practice Guidelines (AHCPR Publication No. 94-0075) and copies of the *Quick Reference Guide for Clinicians* and the *Consumer Version* of each guideline are available through AHCPR's InstantFAX, a fax-on-demand service that operates 24 hours a day, 7 days a week. AHCPR's InstantFAX is accessible to anyone using a facsimile machine equipped with a touchtone telephone handset: Dial (301) 594-2800, push "1", and then press the facsimile machine's start button for instructions and a list of currently available publications.

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